NATIONAL GUARDIAN LIFE INSURANCE COMPANY
GREIVANCE PROCEDURE

If an Insured Person has a grievance or is appealing a grievance decision, contact us either orally or in writing:
The Claims Administrator:
[TPA Name
Toll-free number]

Notice to Insured
Upon the Insured Person's notice of a grievance, we or our agent shall provide timely, adequate, and appropriate notice to each insured of:

1. the grievance procedure required under Indiana law;
2. the external grievance procedure required under Indiana law;
3. information on how to file a grievance and a request for an external grievance review permitted under Indiana law; and
4. a toll free telephone number through which an Insured Person may contact Us at no cost to the Insured Person to obtain information and to file grievances.

Resolution of Grievances:
We will:

1. Acknowledge the receipt of a grievance given orally or in writing to the Insured Person within five (5) business days after receipt of the grievance;
2. Document the substance of the grievance and any actions taken;
3. Investigate the substance of the grievance, including any aspects involving clinical care;
4. Notify the covered individual of the disposition of the grievance and the right to appeal; and
5. Appoint at least one (1) individual to resolve a grievance.
6. Provide the Insured Person filing a grievance the following standard time lines:

(a) A grievance will be resolved as expeditiously as possible, but not more than twenty (20) business days after we receive all information reasonably necessary to complete the review. If We are unable to make a decision regarding the grievance within the twenty (20) day period due to circumstances beyond Our control, We shall:
(1) before the twentieth business day, notify the Insured Person in writing of the reason for the delay; and
(2) issue a written decision regarding the grievance within an additional ten (10) business days.
(b) We shall notify an Insured Person in writing of the resolution of a grievance within five (5) business days after completing an investigation. The grievance resolution notice will include the following:
(1) a statement of Our decision;
(2) a statement of the reasons, policies, and procedures that are the basis of the decision;
(3) notice of the Insured Person's right to appeal the decision; and
(4) the department, address and telephone number through which an Insured Person may contact a qualified representative to obtain additional information about the decision or the right to appeal.

Resolution of Appeals of Grievance Decisions:

We will:

1. Acknowledge the receipt of an appeal of a grievance decision given orally or in writing to the Insured Person within five (5) business days after the appeal is filed;
2. Document the substance of the appeal and any actions taken by the Policyholder Service and Claims Committee;
3. Investigate the substance of the appeal, including any aspects involving clinical care;
4. Notify the covered individual of the disposition of the appeal and that the Insured Person may have the right to further remedies allowed by law;
5. Provide the Insured Person filing an appeal of a grievance decision the following standard time lines:

(a) An appeal of a grievance decision will be resolved as expeditiously as possible, but not more than forty-five (45) days after the appeal is filed.

(b) We shall notify an Insured Person in writing of the resolution of an appeal of a grievance decision within five (5) business days after completing an investigation. The appeal resolution notice will include the following:

(1) a statement of Our decision;

(2) a statement of the reasons, policies, and procedures that are the basis of the decision;

(3) notice of the Insured Person's right to further remedies allowed by law, including the right to external grievance review by an independent review organization; and

(4) the department, address and telephone number through which an Insured Person may contact a qualified representative to obtain additional information about the decision or the right to an external grievance review.

External Grievance Procedural Requirements:

1. An external grievance procedure established under Indiana law must allow the Insured Person or an Insured Person's representative to file a written request with Us for an external grievance review of Our appeal resolution not more than one hundred twenty (120) days after the Insured Person is notified of the resolution.
2. An Insured Person may not file more than one (1) external grievance of Our appeal resolution.
3. The independent review organization and the medical review professional conducting the external review may not have a material professional, familial, financial, or other affiliation with any of the following:

(a) Us, the insurer;

(b) any of Our officer, director, or management employees;

(c) the Insured Person requesting the external grievance review.

4. The Insured Person who files an external grievance shall:

(a) not be subject to retaliation for exercising the right to file an external grievance;

(b) be permitted to utilize the assistance of other individuals, including health care providers, attorneys, friends, and family members throughout the review process;

(c) cooperate with the independent review organization by:

(1) providing any requested medical information; or

(2) authorizing the release of necessary medical information

5. The Insured Person shall not pay any of the costs associated with the services of an independent review organization. All costs must be paid by Us.
6. The determination by the review organization shall:

(a) Within fifteen (15) business days after the appeal is filed make a determination to uphold or reverse Our appeal resolution based on information gathered from the Insured Person or Insured Person's representative, the treating health care provider, and any additional information that the independent review organization considers necessary and appropriate.

(b) apply standards of decision making that are based on objective clinical evidence and the terms of this Policy;

7. The review organization shall:

(a) notify Us and the Insured Person of the determination made within seventy-two (72) hours after making the determination;

(b) upon the request of the Insured Person, provide to the Insured Person all information reasonably necessary to enable the covered individual to understand the:

(1) effect of the determination on the Insured Person; and

(2) the manner in which We may be expected to respond to the determination.

Submission of New Information

1. If, at any time during an external review performed under this Policy, the Insured Person submits information to Us that is relevant to Our resolution of the Insured Person's Appeal of a Grievance Decision and that was not considered by Us under the Internal Grievance Procedures:

(a) We may reconsider the resolution; and

(b) if We choose to reconsider, the Independent Review Organization shall cease the external review process until the reconsideration is complete.

2. We shall reconsider the resolution of an Appeal of a Grievance Decision due to the submission of new information and notify the Insured Person of Our decision within fifteen (15) days after the information is submitted.

3. If the decision reached under is adverse to the Insured Person, the Insured person may request that the Independent Review Organization resume the external review under the policy.

4. If based on the new information submitted to us We choose not to reconsider Our resolution we shall forward the new information to the Independent review Organization not more than two (2) business days after We receive it.

Grievance means any dissatisfaction expressed by or on behalf of an Insured Person regarding:

1. a determination that a service or proposed service is not appropriate or medically necessary;
2. a determination that a service or proposed service is experimental or investigational;
3. the availability of participating providers;
4. the handling or payment of claims for health care services; or
5. matters pertaining to the contractual relationship between:

(a) an Insured Person and an insurer; or

(b) a group policyholder and an insurer

and for which the Insured Person has a reasonable expectation that action will be taken to resolve or reconsider the matter that is the subject of dissatisfaction.

NOTICE
Questions regarding your policy or coverage should be directed to:
National Guardian Life Insurance Company
c/o Administrator: [TPA Name
TPA Toll-Free Number]

If you (a) need the assistance of the governmental agency that regulates insurance; or (b) have a complaint you have been unable to resolve with your insurer you may contact the Department of Insurance by mail, telephone or email:

State of Indiana Department of Insurance
Consumer Services Division
311 West Washington Street, Suite 300
Indianapolis, Indiana 46204
Consumer Hotline: (800) 622-4461; (317) 232-2395
Complaints can be filed electronically at www.in.gov/idoi.